

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-011395

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 137 Primary Registration District No. 4218 Registrar's No. 107

FILED APR 8 1963

1. PLACE OF DEATH a. COUNTY <u>Henry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Benton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP, only) <u>Windsor</u>		c. CITY OR TOWN <u>Ionia</u>	
Length of stay in 1b <u>4 days</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Windsor Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>1mi. West &amp; North of Ionia</u>	
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Edith</u> Last <u>Willis</u>		4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/7/1878</u>
9. AGE (last birthday) <u>84</u>		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (City and state or country) <u>Ionia, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Wesley Willis</u>		13b. MOTHER'S MAIDEN NAME <u>Maria Blanchard</u>	
14. NAME OF HUSBAND OR WIFE <u>None</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Irene Browning, Ionia, Missouri</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Collapse</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>Bronchopneumonia</u> DUE TO (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>3 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>  </u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>  </u>	
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> Month, Day, Year <u>  </u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. CITY, TOWN, OR LOCATION <u>  </u>	
20g. COUNTY <u>  </u>		20h. STATE <u>  </u>	
21. I attended the deceased from <u>March 13, 1963</u> to <u>April 1, 1963</u> and last saw her <u>alive</u> on <u>April 1, 1963</u> Death occurred at <u>10:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>William J. Smith M.D.</u>		22b. ADDRESS <u>Windsor, Mo.</u>	
22c. DATE SIGNED <u>4/2/63</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>4/8/1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cole Camp Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Cole Camp, Missouri</u>		23e. STATE <u>Mo.</u>	
24. FUNERAL DIRECTOR <u>Clifford Gouge, Windsor, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4-3-1963</u>	
26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>		27. ADDRESS <u>  </u>	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

VS.300  
Rev. 4/59

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APR 11 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Clifford Louge*

Licensed Embalmer No.

*5014*

P. O. Address

*Windsor, Ma*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.